PRINTED: 12/04/2012

		AND HUMAN SERVICES  & MEDICAID SERVICES	15t	<u>走</u>	1/13/13		APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL		CONSTRUCTION	(X3) DATE SU COMPLE	RVEY TED
		445464	B. WING	G		11/29	/2012
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		
HILLVIEW HEALTH CENTER					HILLVIEW DRIVE ABETHTON, TN 37643		
(X4) ID PREFIX TAG	(EACH DÉFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
F 166	A resident has the facility to resolve grievance.  A resident has the facility to resolve grievave, including the of other residents.  This REQUIREME by: Based on medical documentation revialled to respond ti resident (#9) of this The findings included Resident #9 was a 23, 2012, with diagental Anxiety, Depression Medical record reviate Data Set (MDS) do the resident was a decision making.  Interview with the 2012, at 4:00 p.m. revealed the resident was a decision making.  Interview at this tir wallet were missing Service was made the grievance.  Interview with the November 28, 20	TO PROMPT EFFORTS TO ANCES  right to prompt efforts by the rievances the resident may se with respect to the behavior.  NT is not met as evidenced record review, facility iew, and interview, the facility mely to a grievance for one rty-two residents reviewed.  led:  dmitted to the facility on May proses including Dementia, on, and Diabetes Mellitus.  riew of the quarterly Minimum ated October 9, 2012, revealed ognitively intact for daily	F1	166	The Social Services Director completed a Concern, & Comform related to the missing it discussed in Resident #9 care meeting by the daughter on 1 The Social Service Director to contacted resident's other dawhich purchased the item, on 11/27/12 and obtained a detail description of the missing ite item's worth. The Social Ser Director notified facility staff missing item on 11/27/12. Se Service Director replaced misitem on 11/28/12.  The Director of Nursing reviet the 24 hour reports for previously to determine if any missitems that have been reported follow up for each from 11/2 12/14/12. The Social Service Director reviewed the last 90 care plan meeting notes to de any missing items that have been reported and the appropriate up for each from 11/27/12 - 12/14/12. No other residents found to be affected.  Licensed Nurses, Nursing As Dictary, Housekeeping, Laura Activities, and Social Service in-serviced on the Comment Concern program by the Director program program program program program program program program program prog	em e plan 1/27/12. hen ighter, illed m & the vice f of ocial ssing ewed ous 90 sing l and the 7/12 — days of termine icen follow were sistants, idry, es were and extor of	12/14/12
		VIDER/SUPPLIER REPRESENTATIVE'S SIG	NATI IOP		Nursing from 11/27/12 - 12/1	14/12.	(XB) DATE
LABORATO	KT DIKECTOKS OK PHO	TO CONTRACT THE RESERVITATION OF	, y 11 W 1 M	-	Admin in that	v 13	- <del> </del> ']-['

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation. program participation.

FORM CMS-2567(02-99) Pravious Versions Obsolete

Evant ID: 1L2I11

Facility ID: TN1002

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PRINTED: 12/04/2012 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING. 445464 11/29/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1666 HILLVIEW DRIVE HILLVIEW HEALTH CENTER **ELIZABETHTON, TN 37643** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Comment and Concern program F 166 F 166 Continued From page 1 education will be added to facility made aware during a care plan meeting the purse orientation by the Director of and wallet were missing. Nursing ongoing. Interview with the Director of Social Service on The Social Service Director and/or November 28, 2012, at 3:50 p.m., at the Station Director of Nursing will review Two Nurse's Station, confirmed the facility failed 100% of items reported missing to to formally document the resident's concern, after a care plan meeting, and failed to respond to the ensure follow up is completed timely grievance in a timely manner. daily X 1 week, weekly X 3 weeks, 483.20(d), 483.20(k)(1) DEVELOP and then monthly X 2 months and/or F 279 COMPREHENSIVE CARE PLANS 100% compliance. Results obtained will be reported to the Quality A facility must use the results of the assessment Assurance/Performance to develop, review and revise the resident's Improvement Committee. The comprehensive plan of care. Quality Assurance/Performance The facility must develop a comprehensive care Improvement Committee consists of plan for each resident that includes measurable the Administrator, the Director of objectives and timetables to meet a resident's Nursing, Minimum Data Set medical, nursing, and mental and psychosocial Coordinator, Rehabilitation Manager, needs that are identified in the comprehensive Medical Director, Social Services assessment. Director, Environmental Services Director, Maintenance Director, The care plan must describe the services that are Dietary Manager, and the Activities to be furnished to attain or maintain the resident's Director. highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided F279 due to the resident's exercise of rights under The care plan for Resident #5 was §483.10, including the right to refuse treatment updated by MDS Nurse to reflect 12/14/12 under §483,10(b)(4). anti-psychotic use, interventions. monitoring, and potential side effects on 11/30/12. The Director of This REQUIREMENT is not met as evidenced Nursing assessed Resident #5 on

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Based on medical record review, observation,

and interview, the facility failed to develop a

identified.

11/30/12. No adverse outcomes

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		445464	B. WING		11/29/	2012
NAME OF PROVIDER OR SUPPLIER  HILLVIEW HEALTH CENTER			16	EET ADDRESS, CITY, STATE, ZIP CODE 166 HILLVIEW DRIVE LIZABETHTON, TN 37643		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREFIX YAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	NULD BE	(X5) COMPLETION DATE
F 279	anti-psychotic for or residents reviewed. The findings included Resident #5 was a 1993, with diagnost (failure of muscula Gastrointestinal Bloom Medical record revident had long problems; severel or behavior symptoms psychotic Disorder anti-psychotic for Medical record reviand Medical record reviand Medical record reviand Medical record reviant Medical record reviant Medical record reviant the forms were bloom pleted by starting the forms to more effects monitored Medical record reviant Medical recor	re plan to reflect use of an one resident (#5) of thirty-two including to the facility on July 6, see including Dementia, Ataxia or coordination), Psychosis, and eed.  View of the Quarterly Minimum obtober 5, 2012, revealed the and short term memory y impaired cognition; no mood orns; active diagnosis of or; and had received an seven of the last seven days.  View of the Physician's Orders deceived Haldol (anti-psychotic) ory evening for agitation since oview of the Behavior Forms for anti-psychotic side effects, but ank and had not been of the indicate the behavior interventions, or side	F 279	Current care plans were review by the Director of Nursing on 11/30/12 – 12/14/12 to ensure residents using anti- psychotics plans reflect usage, intervention monitoring, and potential side effects. No other residents were found to be affected.  Licensed Nurses were in-service by the Director of Nursing on updating care plans related to psychotic usage, interventions monitoring, and potential side effects on 11/30/12 - 12/14/12 Updating care plans with antipsychotic usage will be accounting orientation by the Director of Nursing orientation by the Director of Nursing will 100% of care plans of resident anti- psychotics weekly X 4 withen monthly X 2 months and 100% compliance. Results ob will be reported to the Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee conthe Administrator, the Director Nursing, Minimum Data Set Coordinator, Rehabilitation Manager, Medical Director, Services Director, Environme Services Director, Environme Services Director, Environme Services Director, Maintenan Director, Dietary Manager, at Activities Director.	ced anti ded to ector review t on veeks, lor stained y e sists of or of codal ental ce	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		445464	B. WING	·····	11/2	9/2012	
	ROVIDER OR SUPPLIER V HEALTH CENTER		160	ET ADDRESS, CITY, STATE, ZIP COD SE MILLVIEW DRIVE IZABETHTON, TN 37643	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR- (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE	
F 281 SS=D	p.m., November 2 a.m., and 1:30 p.m at 8:35 a.m., rever sleeping with cover fidgeting and spea Interview with the November 29, 20- conference room, to be care planner care plan was not effects and interve of anti-psychotics 483.20(k)(3)(i) SE PROFESSIONAL The services provimust meet profes  This REQUIREM by: Based on medicate documentation, in facility failed to for resident (#9) of the failed to complete an anti-psychotic residents reviewed The findings included Resident #9 was 23, 2012, with dia	flovember 27, 2012, at 4:20 8, 2012, at 7:45 a.m., 10:15 n., and on November 29, 2012, aled the resident was in bed, ers over head or restless, aking nonsensical language.  Director of Nursing on 12, at 9:40 a.m., in the confirmed anti-psychotics were do to include side effects and the comprehensive to reflect side entions related to administration ERVICES PROVIDED MEET STANDARDS  Indeed or arranged by the facility sional standards of quality.  ENT is not met as evidenced all record review, review of facility aterview, and observation, the allow physician's order's for one nirty-two residents reviewed and the behavior monitoring for use of for one resident (#5) of ten ed for unnecessary medications.	F 281	Resident #9 MD and responsarty were notified by the Nursing on 11/28/12 that Continued no new orders at this to Director of Nursing assess Resident #9. No adverse of identified.  Resident #5 was assessed Director of Nursing on 12. Resident #5 behavior monform was updated to reflect behavior by the Director of nursing on 12/29/12.	Director of C&S had ered. MD time. The sed entcomes by the /29/12. ittoring et current	12/14/12	
	23, 2012, with dia	agnoses including Dementia,			1	short Page 4	

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PRINTED: 12/04/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING . 445464 11/29/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1666 HILLVIEW DRIVE HILLVIEW HEALTH CENTER ELIZABETHTON, TN 37643 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREF!X PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LEC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 281 F 281 Continued From page 4 The Director of Nursing reviewed residents with orders for C&S for Medical record review of a Physician's order last 30 days. All other C&S were dated November 19, 2012, revealed "...Cath UA determined to have been completed (urinalysis) C&S (culture and sensitivity)..." as ordered. The Director of Nursing reviewed Medical record review of a laboratory result dated behavior monitoring forms for November 19, 2012, revealed "...await C&S..." current residents and updated as appropriate on 12/12/12. No other Review of facility documentation on November 28, 2012, revealed no C&S had been performed residents were found to be affected. by the laboratory. Licensed Nurses were in-serviced by Interview with the Director of Nursing (DON) on the Director of Nursing on following November 28, 2012, at 1:55 p.m., in the DON up on C&S when ordered on : office, confirmed the facility failed to follow a 11/28/12 - 12/14/12, C&S follow up physician's order for a C&S for resident #9. will be added to licensed nurse orientation by the Director of Nursing ongoing. Resident #5 was admitted to the facility on July 6, 1993, with diagnoses including Dementia, Ataxia Licensed Nurses were in-serviced by (failure of muscular coordination), Psychosis, and Director of Nursing on completing Gastrointestinal Bleed. behavior monitoring forms on 11/28/12 - 12/14/2012, Behavior Medical record review of the Quarterly Minimum Monitoring Forms will be added to Data Set dated October 5, 2012, revealed the licensed murse orientation by the resident had long and short term memory Director of Nursing ongoing. problems; severely impaired cognition; no mood

Medical record review revealed Behavior Forms

agitation since April 5, 2011.

or behavior symptoms; active diagnosis of

Medical record review of the Physician's Orders

(anti-psychotic) 2.5 milligrams every evening for

and Medication Administration Records (MAR)

revealed the resident had received Haldol

Psychotic Disorder; and had received an anti-psychotic for seven of the last seven days.

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compliance.

The Director of Nursing and/or

Nursing Supervisor will review telephone orders & 24 hour report to

identify residents with C&S and

to ensure C&S is completed as

ordered weekly X 4 weeks, then

monthly X 2 months and/or 100%

100% of residents with C&S ordered

PRINTED: 12/04/2012 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 11/29/2012 445464 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1666 HILLVIEW DRIVE HILLVIEW HEALTH CENTER ELIZABETHTON, TN 37643 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) The Director of Nursing and/or F 281 F 281 Continued From page 5 Nursing Supervisor will review were present with the MARs for May through 100% of behavior monitoring forms November 2012, and were printed with behavior weekly X 4 weeks, then monthly X 2 symptoms, interventions, side effects, number of episodes, and outcomes to be monitored. Further months and/or 100% compliance. review of the Behavior Forms revealed all the Results obtained will be reported to forms were blank and had not been completed by the Quality Assurance/Performance staff. Improvement Committee. The Quality Assurance/Performance Observations on November 27, 2012, at 4:20 Improvement Committee consists of p.m., November 28, 2012, at 7:45 a.m., 10:15 the Administrator, the Director of a.m., and 1:30 p.m., and on November 29, 2012, Nursing, Minimum Data Set at 8:35 a.m., revealed the resident was in bed. Coordinator, Rehabilitation Manager, sleeping with covers over head or restless, fidgeting and speaking nonsensical language. Medical Director, Social Services Director, Environmental Services Interview with the Director of Nursing on Director, Maintenance Director. November 29, 2012, at 9:40 a.m., in the Dietary Manager, and the Activities conference room, confirmed staff were to Director. complete the Behavior Forms daily and the forms had not been completed. F 323 483,25(h) FREE OF ACCIDENT F 323 <sup>1</sup> HAZARDS/SUPERVISION/DEVICES SS=D The beauty shop was secured and 12/14/12 The facility must ensure that the resident locked by Director of Nursing on environment remains as free of accident hazards 11/26/12. as is possible; and each resident receives Beantician & LPN #1 were inadequate supervision and assistance devices to serviced on 11/26/2012 by the prevent accidents. Director of Nursing on keeping the beauty shop door locked when unattended. This REQUIREMENT Is not met as evidenced Current residents have potential to be

FORM CMS-2567(02-98) Previous Versions Obsolete

free of accident hazards.

Based on observation, review of Material Safety

Data Sheet, and interview, the facility failed to ensure that the resident environment remained

bv:

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Event ID: 1L2I11

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affected. No other residents were

identified as having been affected.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED		
		445464	ß. Wil	€G		11/2	3/2012
–	ROVIDER OR SUPPLIER W HEALTH CENTER			16	EET ADDRESS, CITY, STATE, ZIP CODE 566 HILLVIEW DRIVE LIZABETHTON, TN 37643 PROVIDER'S PLAN OF CORREC	TION	(85)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		- ALL ACADECATA CATION CHOILD RE		(X5) COMPLETION DATE
F 328	a.m., in the Beauty unlocked, a curling hot to touch, and a (disinfectant solution of children. Observation reveaus hop, with License confirmed the curl barbicide was not observation reveaus Shop, walked down Beauty Shop door Review of Materia Barbicide reveales kin and eyesSi children"  Observation and 2012, at 10:48 a.r Director of Nursin iron was hot, the cabinet and the Blocked. 483.25(I) DRUG UNNECESSARY  Each resident's dunnecessary drug when used indications for its	ded:  by Shop, revealed the door giron on the sink plugged in, a 64 ounce bottle of barbicide on) labeled keep out of reach rvation and interview on 12, at 10:43 a.m., in the Beauty ed Practical Nurse (LPN) #1 ing iron was hot and the in a locked cabinet. Continued led LPN #1 exited the Beauty on the hall, and failed to lock the  """Health Hazards: Irritating to torage: Keep out of reach of Interview on November 26, m., in the Beauty Shop, with the ag (DON) confirmed the curling barbicide was not in a locked leauty Shop door should be REGIMEN IS FREE FROM		323	Licensed Nurses and Nursing Assistants were in-serviced by Director of Nursing on ensuring beauty shop door is locked with unattended by on 11/26/12—12/14/12.  Ensuring beauty shop door is when unattended will be additicensed nursing and nursing assistant orientation by the English of Nursing ongoing.  Director of Nursing and/or Nursing ongoing.  Ensure the Indianate it is locked unattended five times per we weeks, then monthly X 2 monthly X 2 monthly X 2 monthly Assurance/Performation of Nursing of Nursing will be reported the Quality Assurance/Performating of Nursing, Minimum Data Section of Nursing of	tooked ed to licetor lursing beauty led when lock X 4 boths orted to rmance he lunce	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		COMPLETED	
		445464	B. WIN	iG		11/29	/2012
	ROVIDER OR SUPPLIER			16	EET ADDRESS, CITY, STATE, ZIP CODE 186 HILLVIEW DRIVE LIZABETHTON, TN 37643 PROVIDER'S PLAN OF CORRECT	TION	()(5)
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	IULD BE I	COMPLETION DATE
F 329	combinations of the Based on a compresident, the facility who have not used given these drugs therapy is necessary as diagnosed and record; and reside drugs receive grade behavioral interverse contraindicated, in drugs.  This REQUIREME by: Based on medications were resident (#48) of the facility failed to medications were resident (#48) of the findings inclusively the facility failed to medications were resident (#48) of the findings inclusively failed to the facility failed to the findings inclusively failed to the findings inclusivel	er discontinued; or any e reasons above.  chensive assessment of a y must ensure that residents if antipsychotic drugs are not unless antipsychotic drug ary to treat a specific condition documented in the clinical ints who use antipsychotic drug dose reductions, and intions, unless clinically an effort to discontinue these services are unnecessary not administered for one en sampled residents of its reviewed.	F	329	Resident #48 MD and resp party were notified on 10/3 lab results that organism were sistant to antibiotic and a was changed. Resident #48 assessed by the Director of on 11/26/12. No adverse or identified.  The Director of Nursing recurrent residents on antibiotic prescribed on 11/12/14/12. No other resident be affected.  Licensed Nurses were insected on appartibiotics based on C&S residents are placed on appartibiotics based on C&S residents are placed on appartibiotics based on C&S residents are placed on the Nurse orientation by the Director of Nursing by ongoing.  Director of Nursing and/or Supervisor review 100% of ensure appropriate antibiotic prescribed weekly X 4 week monthly X 2 months and/or compliance. Results obtained	31/12 per ras not untibiotic was not untibiotic was Nursing atcomes viewed atics to esistant to /26/12 - ts found to erviced by uring ropriate esults on otic licensed rector of Nursing C&S to cs are ks, then 100%	12/14/12
,	order dated Octo	escular Disease.  Eview of a physician's telephone ber 23, 2012, revealed "UA  Evicuation (culture and sensitivity)cath"			reported to the Quality Assurance/Performance		

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		445464	B. WING		11/2	9/2012
	ROVIDER OR SUPPLIER		16	EET ADDRESS, CITY, STATE, ZIP CO 166 HILLVIEW DRIVE LIZABETHTON, TN 37643	DDE	
(X4) ID PREFIX TAG	(FACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL. R LSC IDENTIFYING INFORMATION)	IP PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 329	Medical record re order dated Octo "Macrobid (anti (per mouth) BID (days)"  Medical record re dated October 2: Enterobacter Aerwas not sensitive Medical record re order dated October dated Oct	eview of a physician's telephone ber 25, 2012, revealed biotic) 100 mg (milligram) po (twice daily) x (times) 10 d eview of the final culture report 5, 2012, revealed the organism regenes had been identified and e to Macrobid.  eview of a physician's telephone ober 31, 2012, revealed "Ciprong po q 12 hours x 3 daysC&S	F 329	Improvement Committee Quality Assurance/Performent Committee the Administrator, the Department of Nursing, Minimum Date Coordinator, Rehabilitate Medical Director, Social Director, Environmentate Director, Maintenance In Dietary Manager, and the Director.	ormance e consists of irector of a Set tion Manager, I Services I Services Director,	
		Supplies 11 215	<u>i.</u>	acility ID: TN1002	If continuation s	heet Page 9 of